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**Health, Education, and  
Human Services Division**

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October 8, 1999

The Honorable Richard Burr  
The Honorable Peter Deutsch  
The Honorable James C. Greenwood  
House of Representatives

Subject: Medicare: Outpatient Rehabilitation Therapy Caps Are  
Important Controls But Should Be Adjusted for Patient Need

To curb rapid spending growth, the Balanced Budget Act of 1997 (BBA) imposed payment controls for several types of Medicare providers that had previously been reimbursed on a cost basis. For outpatient rehabilitation therapy in particular, BBA required Medicare to pay providers on the basis of a fee schedule; it also limited coverage beginning in 1999.<sup>1</sup> Specifically, the law provided for an annual \$1,500 per-beneficiary cap on payments for outpatient physical therapy and speech/language pathology services combined and a separate \$1,500 cap on outpatient occupational therapy.<sup>2</sup> Services provided by hospital outpatient departments (OPD) are exempt from the \$1,500 caps.

Rehabilitation therapy providers have raised concerns that the \$1,500 limits will arbitrarily curtail necessary treatments for Medicare beneficiaries, particularly victims of stroke, hip injuries, or multiple medical incidents within a single year. These concerns have led to several legislative proposals to include numerous exceptions to the caps or eliminate them altogether. However, little evidence other than anecdotes has been presented to identify access problems resulting from these caps. In July 1999, you asked us to provide information on the (1) rationale for imposing per-beneficiary limits on Medicare's coverage of rehabilitation therapy services and (2) effect of the therapy caps on Medicare beneficiaries' access to needed care. To address these questions, we

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<sup>1</sup>P.L. 105-33, sec. 4541.

<sup>2</sup>Physical therapy includes treatments—such as whirlpool baths, ultrasound, and therapeutic exercises—to relieve pain, improve mobility, maintain cardiopulmonary functioning, and limit the disability from an injury or disease. Speech/language pathology services include the diagnosis and treatment of disorders of communication, swallowing, oral motor and related cognitive functions. Occupational therapy helps patients learn the skills necessary to perform daily tasks, diminish or correct pathology, and promote health.

analyzed Medicare provider-of-services data; reviewed analyses by the Medicare Payment Advisory Commission (MedPAC) of Medicare payment data and prior GAO reports on this subject; and interviewed officials of MedPAC and the Health Care Financing Administration (HCFA), the agency responsible for administering Medicare. This work was performed between July and September 1999 in accordance with generally accepted government auditing standards.

In brief, the per-beneficiary caps on coverage of outpatient rehabilitation therapy services are part of a larger effort by the Congress to curb Medicare spending for post-acute care services. In particular, Medicare spending for outpatient rehabilitation therapy services, between 1990 and 1996, grew at nearly double the rate of Medicare spending overall. At the same time, inadequate program controls failed to ensure that this spending growth was warranted. Under the fee schedule and coverage caps imposed by BBA, Medicare can moderate the price and utilization of these services.

The per-beneficiary caps are unlikely to affect the vast majority of Medicare's outpatient therapy users. Only a small share of beneficiaries uses outpatient therapy extensively. Furthermore, most of the users with greater needs will likely have access to hospital OPDs, which are not subject to the \$1,500 caps. In addition, owing to HCFA's partial approach to enforcing the caps while year 2000 adjustments are made to Medicare's automated systems, noninstitutionalized beneficiaries can avoid having the caps curtail service coverage by switching providers. However, the caps may restrict coverage for some nursing facility residents. Studies are under way or planned to better assess the effect of the caps and evaluate alternative utilization controls. BBA required HCFA to recommend a need-based payment system by 2001, which could help target payments to beneficiaries who genuinely require more services than are covered under the current dollar limits. Such a system would raise the dollar limits for therapy users with extensive needs and lower them for users with modest needs.

## **BACKGROUND**

Rehabilitation therapy for beneficiaries is provided under the Medicare program's two benefit parts: "hospital insurance," or part A, which covers inpatient hospital, skilled nursing facility, hospice, and certain home health care services; and "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, outpatient rehabilitation services, home health services under certain conditions, diagnostic tests, and ambulance and other medical services and supplies.

A variety of providers offers outpatient rehabilitation services to Medicare beneficiaries. The major providers of outpatient therapy are hospital

OPDs, rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORFs),<sup>3</sup> and nursing facilities. While hospital OPDs served most of the users in 1996, other providers accounted for most of the payments (see table 1).<sup>4</sup>

Table 1: Medicare Outpatient Therapy Users and Payments, by Site of Service, 1996

Site of service	Users (percent)	Payments (percent)
Hospital OPD	58	24
Rehabilitation agency	25	39
Nursing facility <sup>a</sup>	13	29
CORF	4	8

<sup>a</sup>Payments to nursing facilities reflect services provided by outside contractors as well as by nursing facilities themselves.

Source: MedPAC, 1999.

Prior to BBA payment reforms, Medicare experienced rapid growth in the services beneficiaries receive following hospitalization (also called post-acute care services), which had been subject to few spending controls. Rehabilitation therapy services—for both inpatients and outpatients—constituted a substantial share of post-acute care spending. BBA required that skilled nursing facilities (SNFs) and home health agencies—major post-acute care providers under part A—be paid a prospective rate per unit of care, rather than a fee for each service delivered.<sup>5</sup> The expectation was that prospective payment systems would curb Medicare spending by controlling payment rates and utilization. BBA also included changes to part B payment and coverage policies designed to control Medicare spending. The controls over these part B services—those applicable to outpatient rehabilitation therapy services—are the subject of the following discussion.

<sup>3</sup>CORFs offer a broad array of services under physician supervision—such as skilled nursing, psychological services, drugs, and medical devices—and must have a physician on staff.

<sup>4</sup>If these individuals qualify for therapy services under Medicare's home health benefit, payment and coverage rules governing the home health benefit—not the outpatient therapy benefit—would apply. If they do not qualify for the home health benefit, the therapy services provided by home health agencies would be subject to the caps. MedPAC estimates that the share of therapy services provided under the latter condition is small.

<sup>5</sup>A prospective rate is a fixed, predetermined lump-sum payment for each unit of care. Since not all patients require the same amount of care, the rate paid for each patient is "case-mix" adjusted to take into account the nature of the patient's condition and expected care needs.

**CAPS ON OUTPATIENT THERAPY  
COVERAGE PART OF EFFORT TO  
CONTROL RAPID SPENDING GROWTH**

The \$1,500 caps on outpatient physical therapy and speech/language pathology services combined and occupational therapy represent part of a larger BBA strategy to control rapid growth in payments for rehabilitation therapy services. Between 1990 and 1996, overall spending for Medicare grew at an average annual rate of 9.7 percent. In contrast, payments for outpatient rehabilitation therapy during the same period rose at an average rate of 18 percent a year, from \$353 million to \$962 million.<sup>6</sup> By provider, payments to CORFs rose annually an average of 35 percent; rehabilitation agencies, 23 percent; and hospital OPDs, 10 percent.<sup>7</sup> Analyses are not available to indicate, in the aggregate or by provider type, the shares of this spending growth attributable to the number of outpatient therapy users, services per user, or payment per service.

Some of the increase in Medicare spending for outpatient therapy since 1990 was expected because of then-new Medicare requirements for nursing home care. However, some of the spending prior to BBA was also attributable to the financial incentives of the previous payment methods, which encouraged service use, and to the lack of program oversight to prevent inappropriate payments. In response, BBA imposed various payment controls, several of which govern payments for outpatient therapy services.

**Pre-BBA Medicare Lacked  
Sufficient Payment Controls  
for Outpatient Therapy**

As we reported in 1995,<sup>8</sup> the nursing home reforms contained in the Omnibus Budget Reconciliation Act of 1987 required nursing facilities for the first time to conduct a medical assessment of all patients, determine what services (including rehabilitation therapy) they needed to improve their condition, and make those services available. These requirements, which became effective in 1990, increased demand for therapy services. To meet this demand, many nursing facilities contracted with rehabilitation agencies to provide therapy services to their residents. A sharp rise in numbers of rehabilitation agencies occurred after 1992, the year that independent therapists, who were already subject to per-beneficiary cost limits, were placed on a fee schedule. MedPAC notes that

<sup>6</sup>These figures, which are from Health Care Spending and the Medicare Program: A Data Book (MedPAC, July 1998), do not include payments for part B therapy services provided by nursing facilities, independent therapists, or physicians.

<sup>7</sup>Health Care Spending and the Medicare Program: A Data Book (MedPAC, July 1998).

<sup>8</sup>Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

in subsequent years, some independent therapists formed rehabilitation agencies, which were not subject to per-beneficiary coverage limits applied to independent therapists or to a fee schedule, and continued to be reimbursed their reasonable costs.<sup>9</sup>

Prior to BBA, Medicare paid institutional providers<sup>10</sup> based on their “reasonable costs,” a payment method that was not effective in curbing Medicare spending. Moreover, providers of part B therapy services to nursing facility residents had the option of billing Medicare directly, instead of through the nursing facility, without the facility or attending physician affirming whether the services were necessary or provided as claimed. At the same time, scrutiny of these bills by Medicare’s claims processors was not sufficient to spot improbably high costs or levels of services claimed. As we reported in 1996,<sup>11</sup> these circumstances made nursing homes an attractive target for opportunists who could bill Medicare for unnecessary services or services not provided.

### **BBA Payment Reforms Designed To Reward Efficient Provision of Care**

Several reforms in BBA are designed to curtail unnecessary service use and slow expenditure growth: a fee schedule limits the prices Medicare pays for services; per-beneficiary coverage caps seek to limit service use; and a requirement that nursing facilities bill for all services furnished to their residents, including those delivered by outside providers, increases these facilities’ accountability and Medicare’s ability to monitor service use. Specifically, BBA provisions include the following.

- All providers of part B-covered therapy services are paid under the Medicare fee schedule for physicians’ services, effective January 1, 1999. (Previously, only therapy services furnished in physicians’ offices and by independent physical and occupational therapists were paid under the fee schedule.) The fee schedule sets the price Medicare will pay for a given service.
- Beneficiaries receiving outpatient rehabilitation therapy from any provider except a hospital OPD are subject to limits of \$1,500 for physical therapy and speech/language pathology services combined,

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<sup>9</sup>Medicare Payment Advisory Commission, Report to Congress: Context for a Changing Medicare Program (Washington, D.C.: Medicare Payment Advisory Commission, June 1998, p. 81).

<sup>10</sup>Institutional providers include hospitals, skilled nursing and nursing facilities, rehabilitation agencies, and home health agencies. Excluded are private physicians and independently practicing therapists.

<sup>11</sup>Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

and \$1,500 for occupational therapy.<sup>12</sup> Whereas the fee schedule controls per-service prices, these caps are coverage limits to control volume. This provision takes effect this year. Beginning in 2002, the \$1,500 cap will be increased by the rate of health care inflation.

- All bills for part B rehabilitation therapy provided to nursing facility residents must be submitted by the nursing facility; providers other than the nursing facility may no longer bill Medicare directly. This requirement makes nursing facilities accountable for the services provided to their residents and enables Medicare to monitor the services these residents receive.
- By January 1, 2001, HCFA is required to develop recommendations for a revised payment policy for rehabilitation therapy services based on a classification of individuals, in both inpatient and outpatient settings, by diagnostic category and prior use of services. A diagnosis-based system can better account for differences in patients' therapy needs, in contrast to the less targeted utilization control afforded by the caps.

**CAPS EXPECTED TO HAVE MINIMAL EFFECT ON MOST BENEFICIARIES; POTENTIAL EFFECT ON NURSING FACILITY RESIDENTS INCONCLUSIVE**

The per-beneficiary caps will likely affect only a small proportion of therapy users. A MedPAC analysis shows that, in 1996, most users (86 percent) did not exceed \$1,500 in payments for physical therapy and speech/language pathology services combined or for occupational therapy.<sup>13</sup> Furthermore, the proportion of beneficiaries whose use of outpatient therapy services will not exceed \$1,500 in payments could be even higher in 1999. That is, the 1996 data reflect Medicare payments based on provider-reported costs, whereas the fee schedule, which became effective January 1, 1999, likely pays many providers at lower prices for therapy services. Thus, beneficiaries today could receive more services before reaching \$1,500 in payments than under the former cost-based system.

**Mitigating Factors Essentially Remove Coverage Limits for Most Users**

Even for beneficiaries who exceed \$1,500 in Medicare-covered services, mitigating factors exist. First, under the BBA exemption, Medicare beneficiaries have no limits on coverage for rehabilitation therapy

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<sup>12</sup>Independent therapists had been under a \$900 annual limit before BBA.

<sup>13</sup>A July 1998 report sponsored by the National Association for the Support of Long-Term Care and NovaCare, a rehabilitation services company, projects that 87 percent of beneficiaries will not exceed the per-beneficiary cap.

provided by hospital OPDs, which are widely available nationwide. A MedPAC analysis indicates that, in 1996, almost 60 percent of Medicare users of rehabilitation services received care from hospital OPDs. Moreover, our analysis of data from a combination of sources indicates that, in 1998,<sup>14</sup>

- 95 percent of all beneficiaries lived in a county in which there was a hospital OPD that could provide outpatient therapy services,<sup>15</sup>
- 98 percent of beneficiaries in urban counties had access to one of these hospital OPDs, and
- 86 percent of beneficiaries in rural counties had access to one of these hospital OPDs.

A second mitigating factor is that the caps will initially not be applied as specified in BBA. HCFA's implementation of the caps will involve many programming changes to multiple automated information systems—changes that HCFA is unable to undertake now because of its year 2000 preparation efforts. As a result, HCFA's claims processing contractors will be unable to track therapy payments on a per-beneficiary basis across providers. Instead, since January 1, 1999, HCFA has employed a transitional approach to implementing the caps. Under this approach, each provider of therapy services is responsible for tracking its billings for each Medicare patient and stopping them at the \$1,500 threshold. The consequence of this partial implementation is that noninstitutionalized beneficiaries may switch to a new provider when they have reached the \$1,500 limit in order to continue receiving Medicare coverage for outpatient therapy services.

**Nursing Facility Residents at Greater Risk of Exceeding Coverage Limitations Than Other Beneficiaries**

The effect of the per-beneficiary caps on nursing facility residents is less clear. On the one hand, the hospital OPD safety valve is not available to these beneficiaries. HCFA policy explicitly states that the hospital OPD exemption does not apply to therapy services furnished to nursing facility residents. Moreover, under new billing requirements, only the nursing facility in which a beneficiary resides is permitted to bill Medicare for outpatient therapy services provided to the resident, regardless of the entity that actually delivered the services. Therefore, unlike their

<sup>14</sup>We analyzed data from HCFA's December 1998 Provider of Services File, December 1998 Medicare Managed Care Penetration File, and hospitals' fiscal year 1996 Medicare cost reports.

<sup>15</sup>Nationwide in 1996, facilities that provided outpatient rehabilitation therapy included 4,428 hospital OPDs; 195 rehabilitation hospitals; 2,957 rehabilitation agencies; and 585 CORFs.

noninstitutionalized counterparts, nursing facility residents cannot switch providers to restart the \$1,500 coverage allowance.

On the other hand, nursing home residents who could be vulnerable to exceeding the \$1,500 coverage limitations—like those needing rehabilitation therapy for such conditions as stroke or hip fractures—may have other sources of covered care. In such cases these beneficiaries would likely have received rehabilitation services before the outpatient therapy coverage limits begin to apply. For example, individuals suffering a stroke or undergoing hip replacement would likely spend at least 3 days in an acute-care hospital, which, combined with the need for daily skilled nursing care or therapy, would make them eligible for Medicare coverage of a SNF stay. Under Medicare's SNF benefit, beneficiaries can receive up to 100 days of care, during which time the SNF is required to provide all necessary therapy services. When Medicare's SNF coverage ends, a nursing facility resident can continue to receive outpatient therapy services under Medicare part B, subject to the outpatient coverage limits. Under these circumstances, the caps are likely to affect only a portion of therapy users who are nursing facility residents. And of these, some beneficiaries may be eligible for alternative forms of coverage for these services, such as Medicaid or private insurance.

### **Efforts Underway To Monitor and Refine Caps**

Several government entities plan, or have work under way, to analyze Medicare's outpatient rehabilitation therapy payments. These studies will assess the potential and actual effect of the caps and fee schedule. MedPAC is planning to update its outpatient rehabilitation therapy payment analysis using 1998 Medicare claims data. It also plans to monitor and evaluate changes in therapy use across providers and in beneficiaries' utilization of services. The Department of Health and Human Services' Office of the Inspector General has two studies under way regarding outpatient rehabilitation therapy in nursing facilities. The first, which is scheduled to be available this fall, will analyze payments for nursing facility residents in 1998 to determine how the caps would have affected them had they been in place at the time. The second study will examine selected payment data and conduct on-site medical reviews from the first quarter of 1999 when the caps and fee schedule were first in effect.

BBA requires that HCFA report on a patient classification system based on beneficiary therapy needs as a possible alternative to the uniform caps. This report, due January 1, 2001, could be significant because such a system would account for differences in patients' therapy needs and help ensure adequate coverage for those beneficiaries who require an extraordinary level of services. It is likely that such a system would also result in coverage limits that are lower than current levels for beneficiaries

with modest outpatient therapy service requirements. The fact that most users in 1996 would not have been affected by the caps suggests that a need-based approach could have more stringent limits on most users. A need-based method of payment would discourage providers from delivering more services than a patient's health status warrants in order to maximize revenues. Such a system could result in program savings.

### **CONCLUSIONS**

Given various mitigating factors, we believe that most beneficiaries—with the exception of certain nursing facility residents—would not face coverage gaps because of per-beneficiary caps on therapy services. However, detailed information on who will be affected and the extent of the impact are currently unavailable because the caps have not been in effect for a full year. Therefore, modifications of the caps to exclude certain beneficiaries may be premature.

The expectation that few beneficiaries are likely to exceed \$1,500 in services each for combined physical and speech/language therapy services and for occupational therapy services could raise questions about the need for coverage limits at all. However, experience suggests that a fee schedule alone may not control spending if use of services increases, thus undermining BBA's comprehensive strategy for constraining Medicare's outpatient therapy spending. The per-beneficiary caps, as a volume restraint, are integral to the BBA spending control strategy.

Nevertheless, coverage limits should reflect differences in patients' needs. HCFA is required to recommend a patient classification system that could lead to need-adjusted limits. Such adjustments would raise the dollar limits for the categories of patients with extensive service needs and lower them for those with only modest service requirements. If such a system is put in place, the safety valve of the hospital OPD exemption may no longer be needed.

### **AGENCY COMMENTS**

In written comments on a draft of this correspondence, HCFA agreed with our assessment that nursing home residents would be the beneficiaries most likely to feel the effect of the caps. HCFA also expressed concern that the caps are insufficient for a "significant" number of beneficiaries. HCFA's concern is consistent with our contention that a patient classification system is needed to allow Medicare payments for outpatient therapy to reflect patient needs. HCFA stressed the agency's intention to continue to monitor the situation and stated that it would examine possible alternatives to the caps. Such proposals, according to HCFA, would likely require changes in legislation. HCFA also provided technical

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comments that we incorporated into the final correspondence as appropriate.

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We are sending copies of this correspondence to The Honorable Nancy-Ann Min DeParle, HCFA Administrator, and other interested parties, and we will make copies available to others on request. If you or your staff have questions, please call me at (202) 512-7119 or Carol Carter, Assistant Director, at (312) 220-7711. Deborah Spielberg, James E. Mathews, and Hannah F. Fein also made key contributions to this correspondence.



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